STATE EMPLOYEES' LEAVE DONATION PROGRAM

COMPLETE PART I IF DONATING LEAVE TO ANOTHER EMPLOYEE

PART I

EMPLOYEE **MAKING** THE LEAVE DONATION:

NAME: _____ SOCIAL SECURITY:_____

AGENCY:_____ AGENCY CODE:_____

EMPLOYEE **RECEIVING** THE DONATION:

NAME:_____ SOCIAL SECURITY:

AGENCY _____ AGENCY CODE:

TYPE OF LEAVE DONATED:

[ ] SICK* NUMBER OF HOURS: _____

* If donating sick leave, the amount donated when deducted must result in a new balance of at least 240 hours.

I hereby confirm that after making this donation, my sick leave balance will be at least 240 hours.

[ ] ANNUAL NUMBER OF HOURS: _____

[ ] PERSONAL NUMBER OF HOURS:_____

Signature: _____ Date: _____

CERTIFICATION BY APPOINTING AUTHORITY/TIMEKEEPER
(Must be completed within 7 days of receipt of this form)

I _____ , the timekeeper/appointing authority for the employee making the donation, hereby certify that the employee is in compliance with COMAR 17.04.11.22.

Signature: _____ Date: _____

****Please be advised that any unused donated leave will automatically be forfeited to the Leave Bank**

COMPLETE PART II IF RECEIVING DONATED LEAVE FROM ANOTHER EMPLOYEE

PART II

CERTIFICATION BY EMPLOYEE RECEIVING THE DONATION
(Must be completed within 14 days of receipt of this form)

I _____, hereby affirm that I have supplied the required medical documentation and that I have not received more than a total of 2080 hours of donated leave from the Employee Leave Bank and from other employees during State service. I understand that I may not use the donated leave for any continuous period that when combined with all other forms of paid leave, exceeds 16 months. I also understand that I must comply with all requirements established by my personnel system for the use of earned paid sick leave.

Signature: _____ Date:

CERTIFICATION BY TIMEKEEPER OR APPOINTING AUTHORITY OF RECEIVING EMPLOYEE
(Must be completed within 7 days of receipt of this form)

I _____ , hereby certify that I am the timekeeper/appointing authority for _____ (agency) and that I have reviewed the leave records of _____ and determined that the employee has satisfied the requirements for using the donated leave.

Signature: _____ Date: _____

MS 405 (Rvsd.5/99)

STATE EMPLOYEES' LEAVE BANK
MEDICAL REQUEST FORM

1. DATE: _____/_____/_____

2. PATIENT'S NAME: _____

3. DATE OF BIRTH:_____/_____/_____ SEX:_____

4. JOB CLASSIFICATION: _____

5. DIAGNOSIS: (Statement)_____

_____

_____

Provide International Classification of Diseases Code(s) (ICD-9):

_____ _____ _____

6. Approximate date employee should return to:

a. Modified Activities/Duty _____/_____/_____ b. Full Activities/Duty_____/_____/_____

7. Summary of Treatment and anticipated procedures (attach additional sheets, if necessary):

_____

_____

_____

8. Treatment according to Certified Procedure Terms (CPT) Code(s):

_____ _____ _____

9. Please provide detailed information as to what aspect(s) of the position the employee is unable to perform. (Attach additional sheets, if necessary.)

_____

_____

10. Physician's Name: _____

(PRINTED OR TYPED)

_____ _____

(PHYSICIAN'S SIGNATURE) ***(PHONE NUMBER)***

Note: This document shall be treated as a confidential medical record and not placed in the employee's personnel file. Only those individuals with a need to know the information contained in this document, to evaluate and review this request will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this document may be subject to disciplinary action, including termination, as well as any other liability imposed by law.

ALL SECTIONS MUST BE COMPLETED IN ORDER FOR THE REQUEST TO RECEIVE FULL CONSIDERATION.